

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Medical Review Division regarding a medical fee dispute between the requestor and the respondent named above.

## **I. DISPUTE**

1. a. Whether there should be additional reimbursement of \$1,166.00 for date of service, 10/09/01.
- b. The request was received on 8/20/02.

## **II. EXHIBITS**

1. Requestor, Exhibit I:
  - a. TWCC 60
  - b. UB-92(s)
  - c. EOB/TWCC 62 forms/Medical Audit summary
  - d. Medical Record
  - e. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.
2. Respondent, Exhibit II:
  - a. TWCC 60 and Response to a Request for Dispute Resolution
  - b. UB-92(s)
  - c. Medical Audit summary/EOB/TWCC 62 form
  - d. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.
3. Per Rule 133.307 (g) (3), the Division forwarded a copy of the requestor's 14 day response to the insurance carrier on 10/17/02. Per Rule 133.307 (g) (4), the Carrier representative signed for the copy on 10/18/02. The response from the insurance carrier was received in the Division on 10/25/02. Therefore, insurance carrier's response is timely.
4. Notice of Additional Information Submitted by Requestor is reflected as Exhibit III of the Commission's case file.

### III. PARTIES' POSITIONS

1. Requestor: Taken from the Table of Disputed Services

“reimbursement [sic] amount unacceptable – see attached [sic]”

2. Respondent:

“...ACCORDING TO RULE 134.401(a)(4), NO FEE [SIC] EXISTS FOR AMBULATORY SURGICAL CARE, AND SERVICES ARE TO BE PAID AT A FAIR AND REASONABLE RATE UNTIL THE ISSUANCE OF A FEE GUIDELINE. **THERE IS NO MAR FOR OUTPATIENT FACILITY FEES: ONLY ‘FAIR AND REASONABLE’**...THE CARRIER, IN DETERMINING WHAT CONSTITUTES A ‘FAIR AND REASONABLE RATE’ DID CONSIDER THE MEDICARE, PPO AND HMO PAYMENTS, AND REVIEWED THE COMMISSION’S OWN GUIDELINES FOR ACUTE CARE. ACUTE CARE GUIDELINES STATE THAT \$1,118.00 IS A VALID REIMBURSEMENT FOR A FULL DAY OF INPATIENT CARE, OR APPROXIMATELY 24 HOURS.”[sic] BY DEFINITION, OUTPATIENT OR AMBULATORY SURGICAL SERVICES ARE THOSE THAT REQUIRE LESS THAN 90 MINUTES ANESTHESIA TIME AND LESS THAT [SIC] FOUR HOURS OF RECOVERY” [SIC] THIS MEANS THE PATIENT RECEIVES CARE FROM THE FACILITY FOR ¼ TH OF THE TIME OF BEING IN AN INPATIENT SETTING FOR A FULL DAY, AND THE FACILITY IS PAID AT THE **EQUIVALENT OF A ONE DAY INPATIENT STAY. THE ACUTE CARE FEE GUIDELINES WERE USED AS A CONSIDERATION IN DETERMINING REIMBURSEMENT – HOWEVER, THIS DOES NOT MEAN THAT INPATIENT GUIDELINES WERE APPLIED TO THIS SERVICE.** THE CARRIER HAS CONSISTENTLY APPLIED THIS REIMBURSEMENT RATIONALE FOR ALL A.S.C. SERVICES PROVIDED IN 2001....”

### IV. FINDINGS

1. Based on Commission Rule 133.307(d) (1) (2), the only date of service eligible for review is 10/09/01.
2. This decision is being written based on the documentation that was in the file at the time it was assigned to this Medical Dispute Resolution Officer.
3. Per the Requestor’s Table of Disputed Services, the Requestor billed the Carrier \$3,337.94 for services rendered on the dates of service in dispute above.
4. Per the Requestor’s Table of Disputed Services, the Carrier paid the Requestor \$1,118.00 for services rendered on the dates of service in dispute above.
5. The Carrier’s EOBs deny additional reimbursement as “M – IN TEXAS, OUTPATIENT SERVICES ARE TO BE PAID AS FAIR AND REASONABLE.”

6. Per the Requestor's Table of Disputed Services, the amount in dispute is \$1,166.00.
7. The facility provided O.R. services, pharmaceutical products, medical and surgical supplies, non-sterile supplies, IV therapy, Radiology services, anesthesia equipment, EKG monitor, and Recovery Room services.

## **V. RATIONALE**

Medical Review Division's rationale:

The medical documentation indicates the services were performed at an ambulatory surgical center. Pursuant to Rule 133.307 (g) (3) (D), the requestor must provide "...documentation that discusses, demonstrates and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement..." The provider has submitted additional reimbursement data: an example EOB from another carrier for charges billed for the same or similar procedure. However, one example EOB is not sufficient evidence that the Provider's charges are "fair and reasonable". The Provider has failed to meet the criteria of Rule 133.307 (g) (3) (D).

Per Rule 133.304 (i), "When the insurance carrier pays a health care provider for treatment(s) and/or service(s) for which the Commission has not established a maximum allowable reimbursement, the insurance carrier shall:

1. develop and consistently apply a methodology to determine fair and reasonable reimbursement amounts to ensure that similar procedures provided in similar circumstances receive similar reimbursement;
2. explain and document the method it used to calculate the rate of pay, and apply this method consistently;
3. reference its method in the claim file; and
4. explain and document in the claim file any deviation for an individual medical bill from its usual method in determining the rate of reimbursement."

The response from the carrier shall include, per Rule 133.307 (j) (1) (F), "... if the dispute involves health care for which the Commission has not established a maximum allowable reimbursement, documentation that discusses, demonstrates, and justifies that the amount the respondent paid is a fair and reasonable rate of reimbursement in accordance with Texas Labor Code 413.011 and §133.1 and 134.1 of this title;"

The carrier asserts that EOBs do not constitute a pattern substantiating fair and reasonable. While the carrier has indicated that it does consider Medicare, PPO and HMO payments and utilizes the Commission's own guidelines for acute care in its methodology, they have failed to meet the requirements of Rule 133.304 (i). TWCC Rule 134.401 (a) (4) indicates, ambulatory/outpatient surgical care is not covered by the Acute Care Inpatient Hospital Fee Guideline and as such cannot be utilized in determining reimbursement for an ASC. The Carrier has failed to support that their \$1,118.00 payment reflects a fair and reasonable reimbursement.

The payment amount appears to reflect a payment equal to that reimbursed in an acute care setting. The Carrier has failed to expand on how their consideration of Medicare, PPOs and HMOs has contributed to the amount reimbursed.

Due to the fact that there is no current fee guideline for ASCs, the Medical Review Division has to determine which party has provided the most persuasive evidence of what is a fair and reasonable rate. Pursuant to Rule 133.307 (g) (3) (D), the Requestor has not established entitlement to additional reimbursement. Therefore, **no additional** reimbursement is recommended.

The above Findings and Decision are hereby issued this 15<sup>th</sup> day of April 2003.

Pat DeVries  
Medical Dispute Resolution Officer  
Medical Review Division